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Tips for First-Generation College Students

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FROM THE EDITOR: I want to invite you to read the first installment in a new, exciting column series focusing on finding balance and support as you adjust from a high school to college environment. Whether you have taken some precollege classes in high school, entered college as a first-generation student, or are still seeking to "find your way" several years into your college experience, day-to-day life in college brings a new set of challenges that you have probably not encountered any place else. Dr. Ronald Stolberg has made the study of reaching adulthood his life's work. He is a family therapist, university professor, and father of two current college students. Join us in the coming months as he shares his insights on the skills you will need to successfully navigate your new collegiate environment.

Being the first person to go to college in your family is an amazing achievement. Hopefully, many people in your life are celebrating your accomplishment. However, the truth is that if you are the first, all those people cheering you on may not be great resources for the support and insight you will need along the way. Figuring out how navigate college and all that comes with it is tricky, and it is made even harder when you have to do it alone.

If you are the first in your family to go to college, then you are a first-generation (or first-gen) student. If you feel like you are mostly on your own and didn't

receive a lot of support, guidance, or insights about college, then you are probably a first-gen student too. It is a big advantage to have family members who attended college because they can help prepare you for things such as registering for classes, figuring out housing, applying for student loans, the importance of meeting with guidance counselors, and the various support systems available to students, just to name a few.

The good news is that you are not alone. Recent surveys indicate that about 40% of those entering college and 33% of graduates are first-gen. Colleges have shared that your first-gen status not only likely attracted the attention of the admissions department but probably caused your application to be viewed more favorably. Also, colleges describe students like you as being curious, enthusiastic, optimistic, and able to persevere.

The challenges that await a first-gen student are real, but they are not insurmountable. There are practical steps that students like yourself have shared that helped them overcome the obstacles. The following tips are not just for first-generation students but for anyone who feels like they are alone or lack support while they navigate the full college experience.

1. **Find your people.** Attempting to navigate the challenges and stress of college alone is very difficult. You will need a support system that you can trust and that will be there for you when you are confused, frustrated, and even want to quit. Your new

friend group can serve a lot of important rolls in your college life. They may have answers to elusive questions; they can validate your feelings about things being confusing, hard, or frustratingly unclear; and sometimes they can simply be a healthy reminder that college is difficult and requires lots of hard work. Keep your eyes open for a small group of students who are looking to make friends and then hold on to them like they are a treasure. Everyone needs a support system, so the more the merrier when it comes to having good people on your side.

2. Stay in regular contact with your academic advisor.

Advisors should be the first source of answers to confusing questions about schedules, classes, prerequisites, class sequences, degree requirements, and a whole host of other things related to taking classes and graduating. Your college advisor's job is to help you navigate the nuances of the department or program that you are studying in. They would love to get to know you and make things as easy and clear as possible. One of the things we often hear is that students feel like they are bothering their advisor or are a burden to them. Nothing is further from the truth. Get to know your academic advisor and stay in touch as much as you can.

3. Take full advantage of faculty office hours and TA study sessions. There are numerous reasons this is a really good idea. It is a great way to get to know your professors, which can be harder than you think. Office hours and organized study sessions with a teaching assistant are the best place to ask your questions, and you will be pleasantly surprised at the insights that are often shared about exams and grading rubrics. Another reason this is important is that successful navigation of college is made easier with a good mentor. A mentor is anyone who can provide you guidance and direction not just about the class but about the program, the major, and what jobs or internships are important too. Faculty members and more advanced students who are teaching assistants fill this role nicely.

4. Join, join, join. Since you are trying to surround yourself with a great support system, joining clubs and organizations that reflect your values is a wonderful way to meet likeminded people. Clubs with regular meetings help structure your time and provide needed breaks in the monotonous routine of going to class and studying. When you join something there is also a sense of belonging that is important for first-gen students' success. When you feel like you are part of the fabric of the community, you are more likely to invest in it. It is important to know that you belong and are important at your college or university.

5. Consider an on-campus job. A part-time job can be beneficial in several ways. First, it never hurts to have a little extra money because college is expensive. However, the real benefits from an on-campus job are that you are likely to meet a lot of new people that you would never normally cross paths with. Students from other residence halls, advanced students, ones with different majors, and most importantly different backgrounds. Meeting and becoming friendly with a wide array of people on campus is another way to develop a deep

feeling of belonging. As an added bonus, there are sometimes perks like early registration and employee discounts.

6. Stay connected to your family and friends from home. We have discussed how important it is to develop a new support structure in college, but it is equally important to keep connected to the people who are most important in your life. Many of them may not be able to directly help you with school-related issues, but they can absolutely share their love and appreciation for what you are doing. Don't be afraid to share that you are making friends and staying busy; they just want the best for you even if it means having a little less of your attention.

Being a first-generation college student is a great honor. To give yourself the best chance of being successful, you will need to push yourself a little bit outside your comfort zone, but it can be fun and good for you. Making new friends, getting involved on campus, and seeking out advice and mentoring are all ways to get involved and develop the confidence that you belong right where you are. Congratulations and welcome to the start of a life-changing experience.



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Why Don't Psychologists Talk About Their Own Mental Health?

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Clinical psychology has a giant elephant in the room. Despite being a field responsible for understanding, treating, and destigmatizing mental illness, almost nothing is known about the mental well-being of psychologists, themselves, or how psychologists should navigate disclosure of their own lived experiences with mental illness.

In this article, I describe how the lack of research and dialogue surrounding lived experience of psychopathology among clinical psychologists is harmful to the well-being of faculty and students in the field.

A Personal Disclosure

In the spirit of transparency, I open with a brief personal story to share my positionality on this topic.

I am a (holds breath) sixth year PhD student in clinical psychology. I entered graduate school wanting to understand recovery from depression, but very quickly my interests expanded to wanting to understand and reduce mental illness stigma.

What changed? Well, just one week after I was admitted into my graduate program, I lost my older brother, Matt, to suicide. Matt was my best friend and my primary support system—losing him remains the most significant event in my life.

Within this context, I hope it is no surprise when I share that I experienced some combination of depression, grief, and posttraumatic stress disorder for the next two years. I would be lying if I said these mental health experiences didn't interfere with my functioning. But from

a graduate training standpoint, I was still able to operate as a young psychologist by meeting or exceeding all my milestones.

This is where the elephant comes in.

While coping with my trauma, I found it unsettling and ironic that I felt afraid to talk openly about my mental health to colleagues in my clinical psychology program—a training ground for therapists. Rather than inform anyone of my struggling, I concealed my experiences from mentors and supervisors, alike, and gave the illusion that nothing was awry. I defaulted to silence about my own mental health because silence was (and remains) the precedent.

My silence was only reinforced after I learned that I was disqualified from a graduate scholarship because I referenced my brother's suicide in my application—albeit after I was asked to “discuss the development of [my] interest in psychology.” I was informed by an empathic professor that the scholarship committee stated, “He has the awards, publications, and research experience, why would he feel the need to share this?” When I learned that my disclosure was the reason for my rejection, and not my qualifications, I felt defeated. This response implied that I would need to continue hiding a core part of my identity as a researcher to be successful in psychology, including all my lived and family-relevant experiences with mental illness.

My story does not represent every person's experience, but it raises important climate questions about mental illness among clinical psychologists. How common are mental health difficulties

among clinical psychologists? What are the perceptions of psychologists with lived experience? If a psychologist or trainee has a mental illness, or even just a close connection (e.g., familial) to the topic, should they talk about it? What is the harm in continuing to ignore lived experience? Unfortunately, little systematic data and dialogue exists on these questions.

How Common Is Lived Experience of Mental Health Difficulties?

To confront the elephant in the room, my colleagues and I collected data on the prevalence mental health difficulties among clinical psychologists and trainees. We surveyed a representative sample of faculty members and trainees in North American graduate programs in clinical, counseling, and school psychology (Victor et al., 2022a).

Our survey asked respondents two separate questions: whether they had ever experienced “mental health difficulties” and if they had ever been diagnosed with a mental illness by a professional. This method ensured that we captured mental health difficulties that are not captured by a formal diagnosis (e.g., suicidal thoughts, nonsuicidal self-injury), while also ensuring that we could identify respondents who had no access to a mental health provider who could make a formal diagnosis.

From a sample of almost 1,700 participants, we found that 80% of all respondents reported having mental health difficulties at some point, and 48% reported having a diagnosed mental illness (Victor et al., 2022a). These lifetime

rates are similar to those found in studies of mental health difficulties in the general population (Caspi et al., 2020). In other words, like the clients they treat, clinical psychologists are not exempt from experiencing a mental health difficulty.

Depression, generalized anxiety disorder, and suicidal thoughts or behaviors were the three most common difficulties among clinical psychologists and trainees, whereas bipolar and psychotic disorders were among the least common (Victor et al., 2022a). This distribution of specific difficulties was similar to a previous study of mental health difficulties among psychologists in the United Kingdom (Tay et al., 2018).

Our study also investigated the extent that psychologists experience impairment due to their mental health difficulty. When asked to rate their level of impairment on a 4-point scale, 95% of respondents with mental health difficulties—and 80% of those with diagnosed mental illness—reported having “no” or “mild” professional problems related to these experiences. These findings indicate that mental illness does not preclude one’s ability to being a capable and effective psychologist. However, these findings do not reveal how psychologists cope with their mental illness to retain high levels of functioning, nor do they shed light on barriers that may impede one’s ability to cope (Victor et al., 2022b).

Do Psychologists Stigmatize Lived Experience Among Their Own?

If mental illness is common among psychologists, then why is it so rare that psychologists talk openly about their own experiences? One obvious culprit harkens back to my own story; psychologists fear that they will be perceived negatively by their colleagues (Tay et al., 2018). But how do psychologists view their colleagues with lived experience?

Unfortunately, few studies have systematically documented psychologists’ perceptions of lived experience. Most of what can be inferred on this topic is drawn from anecdotal experiences (e.g., Hinshaw, 2008), commentaries (e.g., Kimhy et al., 2022), and advice guides (e.g., Prinstein, 2022). Although these sources do not provide definitive answers about how the field views

lived experience, they suggest that psychologists and trainees have conflicting attitudes about lived experience and its disclosure.

In one sense, there is evidence that lived experience is associated with negative stereotypes. Many professional advice guides explicitly advise graduate applicants against disclosing their own mental health history (see for examples, Devendorf, 2022, or they may be perceived as being unable to function in graduate school. As a result, personal disclosures of lived experience with mental illness may diminish one’s chances of getting admitted—even for strong applicants (Salzer, 2022).

The stigma against mental health disclosure is not limited to clinical psychology trainees (Victor et al., 2022b). The few faculty members who have publicly disclosed their lived experience, including Marsha Linehan, Kay Redfield Jamison, and Stephen Hinshaw, have described the stigma surrounding disclosure within academic psychology (Hinshaw, 2008; Linehan, 2020). Kay Redfield Jamison, for instance, feared “being labeled by [her] academic and medical colleagues as a manic-depressive psychologist rather than being seen as a psychologist who merely had manic-depressive illness” (Salamon, 2019, np).

Although stigma toward lived experience does exist, there is also evidence that lived experience is viewed in a positive light (Devendorf et al., 2022; Kimhy et al., 2022; Victor et al., 2022b). For instance, some psychologists have commented recently on the value of lived experience, including that it can empower a psychologist with insight, passion, and empathy in research and clinical practice (e.g., Victor et al., 2022b).

There is also evidence to suggest that not all mental health disclosures are met with negative reactions. In a study of clinical psychologists with lived experience from the United Kingdom, participants were asked about whether they had disclosed their mental health difficulty and to rate the quality of the experience from 0 (*very negative*) to 10 (*very positive*). Of 425 clinical psychologists with lived experience, 44.5% had disclosed within a work setting, and the average rating was a 6.65 ($SD = 2.55$), implying that there is variability of positive

and negative professional reactions. Kay Redfield-Jamison’s story seems to support this narrative of mixed reactions, commenting on her disclosure, “Most people were kind in ways I could not have imagined. Acts of cruelty and criticism have been far outweighed by innumerable acts of generosity” (Salamon, 2019, np).

In acknowledging the mixture of positive and negative reactions to lived experience, I want to emphasize one point: at this time, there is not enough research to make definitive conclusions about the climate surrounding lived experience and disclosure. I say this because I do not want to inadvertently discourage disclosure by perpetuating fears about lived experience. That said, I also do not want to invalidate the legitimate fears about disclosure. Stigma certainly exists, but the picture is likely more complicated. The pervasiveness and extent of stigma likely varies by contextual factors. How and when a disclosure occurs may impact perceptions of severity, which may affect others’ perceptions about one’s ability to function in graduate school, clinical work, and research. Ultimately, more systematic research is needed to document psychologists’ attitudes about lived experience and disclosure.

Shifting the Culture: Acknowledging the Elephant in the Room

So where does this leave us?

We know most psychologists and trainees have experienced mental health difficulties. We know that most psychologists and trainees are understandably reluctant to talk openly about their own mental health history. And we know that much of this reluctance stems from the uncertainty about reactions to disclosure—uncertainty, which itself, stems from the lack of dialogue and research on this topic. Put otherwise, by avoiding the elephant in the room, clinical psychologists have inadvertently trapped themselves into a cycle of uncertainty, fear, and silence when it comes to talking openly about lived experience of mental health difficulties. The harm caused by this silence goes beyond discussions about climate in psychology training programs.



By avoiding these conversations, clinical psychologists set a dangerous precedent that interferes with their ability to fulfill the missions of clinical psychology: to understand, treat, and destigmatize mental illness. Silencing psychologists with lived experience inherently undermines the possibility that lived experience can provide unique strengths, assets, and perspectives. Many advances in psychology have developed from researchers' leveraging their own mental health experiences, including some evidence-based therapies like Dialectical Behavior Therapy for borderline personality disorder (Linehan, 2020) and Seeking Safety for trauma and substance use disorders (Najavits, 2002).

Avoiding discussions about lived experience also undercuts the field's credibility in reducing mental illness stigma and increasing help-seeking behavior. Clinical psychologists have devoted decades of efforts to reduce stigma in other professions—including the military, law enforcement, and medicine—yet clinical psychology has yet to reckon with its own workplace stigma.

The good news is that there is hope. Clinical psychology can shift its culture to acknowledge the elephant in the room. It is beyond this piece to describe all future directions (for more, see Kimhy et al., 2022; Victor et al., 2022), so I will outline three actionable recommendations regarding disclosure.

1. Validate disclosure of lived experience.

Psychologists can take an immediate step to improving the climate by improving their reactions to someone's mental health disclosure. Drawing on strategies developed from psychological science, recipients of disclosure can take the following steps: (a) identify their own emotional reactions to the disclosure, (b) acknowledge the potential difficulty inherent in the disclosure for the individual disclosing, (c) create a nonjudgmental and empathic space, (d) assess the goal of the disclosure, and (e) work collaboratively with the person disclosing to identify next steps (Barth & Wessel, 2021; Victor et al., 2021).

2. Alleviate uncertainty on disclosure.

Psychologists must improve transparency in contexts where people with lived experience of mental illness may feel pressured to disclose (or not to disclose) their experiences. A common example regards the instructions for personal statements on graduate, internship, and job applications, in which applicants are routinely asked about how they became interested in a clinical psychology career. Given that many clinical psychologists conduct self-relevant research (Devendorf et al., 2021), they may be conflicted about whether they should talk honestly about their personal experiences with mental illness. To remedy these issues and reduce ambiguity, application instructions should note whether lived experience with mental illness is acceptable to include in a personal or research statement—among other contexts (Victor et al., 2022b).

3. Gather data to inform decisions about disclosure.

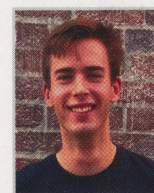
A natural next step is for psychologists to simply conduct more research on lived experience and disclosure. Most advice on disclosure of mental illness is drawn from anecdotal experiences and advice guides. However, the generalizability of this advice is unclear and may even be outdated, given the shifting nature of attitudes about mental illness. As noted above, attitudes about disclosure are likely mixed and vary by context (e.g., disclosure on a graduate application vs. disclosure in a meeting with a trusted mentor). Thus, guidance on disclosure would ideally be informed by

research, such as survey and experimental data on the predictors of positive, negative, and mixed reactions to disclosure.

A decade from now, I hope that clinical psychologists will look back and laugh at the time when our field used to categorically ignore discussion of our own mental well-being. Until then, we have work to do.

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Four Upheavals in Doctoral Admissions

in Clinical and Counseling Psychology

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PhD and PsyD programs in clinical and counseling psychology have recently undergone profound changes in their admissions. Historically, approximately 90% of doctoral clinical and counseling psychology programs required Graduate Record Examination (GRE) scores and in-person interviews for admission (Goldberg et al., 1992; Kuncel et al., 2001; Norcross et al., 2018, 2020). And the percentage of incoming doctoral students had never matched the racial composition of the country or the population they professed to serve (APA, 2019; Callahan et al., 2018). But the COVID-19 pandemic and recent racial justice protests, ignited by such events as the killing of George Floyd and Breonna Taylor, have

dramatically altered those three admission processes, probably permanently.

The fourth upheaval is not a sudden development, but rather a continuing pattern, part of the changing face of American psychology (Howard et al., 1986) or the “feminization” of psychology (Ostertag & McNamara, 1991). Male students are steadily decreasing in numbers relative to female students in health service psychology.

We have systematically tracked these four upheavals in the admissions of American Psychological Association (APA)-accredited doctoral programs in clinical and counseling psychology, which are by far the most popular subfields in psychology. The PhDs and PsyDs awarded in these fields account for more

than 65% of all doctorates awarded in psychology each year (APA, 2019).

Over the past 32 years, we have repeatedly surveyed all APA-accredited programs about their admission requirements, student characteristics, faculty attributes, and interview policies (Norcross & Sayette, 2022). In 2021, for example, we emailed our survey to the training directors of all 247 clinical and 72 counseling psychology programs accredited by APA. We received responses from 309 programs (97% response), and these data are used throughout this article.

Here, in brief, are the four upheavals and how they likely impact future applicants to these doctoral programs. That is, how they may impact *you* and *your peers*.

1. Fewer Programs Requiring GREs

The general Graduate Record Examination (GRE) is a 3-hour and 45-minute computer-based standardized aptitude exam that aims to predict student success in graduate school. The GRE's format is familiar to some students as it closely resembles the Scholastic Aptitude Test (SAT). The GRE has three sections: Verbal Reasoning (V), Quantitative Reasoning (Q), and Analytical Writing (AW). The first two sections are multiple-choice while the last one has a written format.

Traditionally, the vast majority of doctoral programs required students to complete and submit their GRE scores as part of their admissions process. In 2010, for instance, more than 80% of clinical psychology doctoral programs required the GRE (Norcross et al., 2010).

During the initial years of the COVID-19 pandemic, many programs temporarily suspended that requirement, and other programs made the test optional.

Now, the number of programs that require GRE scores has decreased substantially. In 2021, approximately one-third of APA-accredited doctoral programs required GRE scores, one-third were test optional, and the remaining one-third did not consider GRE scores as part of the admissions process. In other words, more than half of APA-accredited programs were not mandating submission of GRE scores this year.

Many of these changes in GRE policies were intended to increase student diversity and to address COVID-19 restrictions. The Council of University Directors of Clinical Psychology (2021), for example, formally voted to discourage its programs from posting average GRE scores of accepted students on their websites in an effort to encourage more racial minority students to apply.

Not only will students have to decide whether to submit their scores but also if they even take the test. If students are applying to multiple PhD and PsyD programs, including those that require the scores, then we recommend taking the GRE.

When GRE scores are optional, we advise applicants to consult with their

advisors in making the most beneficial decision. That decision often comes down to three main points: (a) if the GRE scores are above the average of the previously accepted scores for that program, then they should be submitted, though other considerations (e.g., enhancing diversity) may influence the decision making; (b) if the GRE scores are average, it depends on the strength of the applicants' other credentials; and (c) if the GRE scores are below average for that program, then students should not submit their scores (Norcross & Sayette, 2022).

This transformation poses advantages as well as disadvantages for applicants. One advantage is not needing to prepare for, pay for, and take the GRE. That saves time and money in an already demanding application process. Another advantage occurs for those students who do not perform well on standardized exams, such as the GRE.

At the same time, not having GRE scores forces admissions committees to place more emphasis on other variables in reaching decisions. Research consistently shows that, for competitive doctoral programs in psychology, these are research experience, preadmission interviews, letters of recommendation, personal statements, and grade point averages (APA, 2019; Littleford et al., 2018; Norcross et al., 2005). Of course, applicants who tend to perform well on standardized examinations are relatively penalized and may be disappointed.

2. More Students of Color Attending

The percentages of racial minority students attending doctoral programs in clinical and counseling psychology have been historically underrepresented compared to the general population. That's true of virtually all subjects in graduate school, not only psychology (National Science Foundation, 2021).

However, the percentage of racial minorities enrolled in clinical and counseling programs is steadily increasing—from 16% in 1993 to 35% in 2021 for clinical psychology and from 24% in 1993 to 73% in 2021 for counseling psychology (Norcross et al., 2018, 2020; Norcross & Sayette, 2022). That's right: This last year, one-third of incoming

clinical psychology doctoral students and about three quarters of counseling psychology students identified as BIPOC (Black, Indigenous, & People of Color).

Representation of students of color in the psychology doctoral pipeline in clinical and counseling psychology has obviously improved. At the same time, inequalities in representation remain evident in both race and other marginalized populations (e.g., sexual orientation, people with disabilities, lower socioeconomic status). About 40% of Americans identify as an ethnic minority (Census Bureau, 2019), while 35% of new clinical students self-identify as such. Therefore, more progress in student representation is needed to fulfill psychology's goal of proportional representation and health care equity (APA, 2021).

3. Interview Formats Becoming Flexible

Make no mistake: The preadmission interview is still required by the vast majority of doctoral programs in clinical and counseling psychology. Unlike most other subfields of psychology, admissions committees want to meet you, assess your interpersonal skills, and your fit with their program. The interview continues to be mandated by 92% of counseling and clinical psychology programs.

But the interview format has undergone renovation. Only 9% of clinical programs and 0% of counseling programs in summer 2021 planned to conduct interviews in person (Norcross & Sayette, 2022). Rather, most programs (36% clinical, 58% counseling) made the interview format flexible, giving applicants the choice between an in-person or a virtual format. The remaining programs plan to conduct their interviews only virtually (18% clinical, 16% counseling) or were unsure of how to proceed with the preadmission interview (37% clinical, 26% counseling).

The good news is that these changes have decreased the financial burden on applicants, saving them the expense of traveling and lodging for each program's interview. The changes also permit applicants with invitations to interview at multiple programs on overlapping days, the opportunity to interview at more programs.

The bad news is that, by general consensus, several hours of videoconferencing does not provide the same degree of exposure and experience as actually visiting the program in-person for a day or two. Students will devote at least four or five years to their doctoral studies on campus, so you should travel at some point to the program when accepted, as your finances permit. Depending on the program, you might obtain some funding to defray the costs of such a visit once you are accepted, but before you decide to enroll.

Remember: the dual purpose of the preadmission interview is for the program to check you out *and* for you to check them out. Perhaps right now it seems presumptuous to contemplate evaluating a doctoral program—you will be probably delighted just to be asked to interview! But an on-campus visit will provide you with decisive information on choosing which program to attend eventually. You will investigate clinical opportunities, faculty members, student life, research facilities, housing options, local communities, and the like.

4. Male Students are Decreasing

Health service psychology was the inequitable province of White cisgender men for decades. Not until the 1970s or 1980s did the gender of admitted students begin to resemble the population at large (Howard et al., 1986). Since that time, however, the vast majority of doctoral students in clinical and counseling psychology have been women.

The percentage of women enrolled in APA-accredited clinical psychology programs continues to gradually increase over time, from 67% in 1993 to 79% in 2021 according to our studies. Likewise, in counseling psychology programs, the percentage of women increased from 65% in 1993 to 73% in 2021.

Such trends prove corrective in one sense, but ironic in another. American psychology has clearly grown more diverse and representational in students' cultural identities over time, but at the same time, less representational of the male gender. We vigorously encourage qualified students across all gender identities to apply to clinical and counseling psychology programs.

In Closing

Clinical and counseling psychology doctoral programs have transformed their traditional admission processes. The first three upheavals, by all accounts, directly result from the COVID-19 pandemic and the international reckoning on race. More than half of APA-accredited programs no longer require GRE scores, expensive in-person interviews have given way to flexible and less expensive options (particularly videoconferencing), and the percentage of racial minorities in health-service psychology has consistently risen. In fact, students of color represent approximately half of the new students in APA-accredited clinical and counseling psychology programs.

Noble efforts to enhance gender representation in the psychology pipeline and emerging patterns in health care employment (Adams, 2010; Shannon et al., 2019) have led to a proportional dearth of male students in health service psychology. Our hope, in bringing attention to this matter, is to inform and reassure applicants of all gender identities that clinical and counseling psychology can be for you, too.

Exciting times are ahead. Ensure that you know what these upheavals mean for you and your application.

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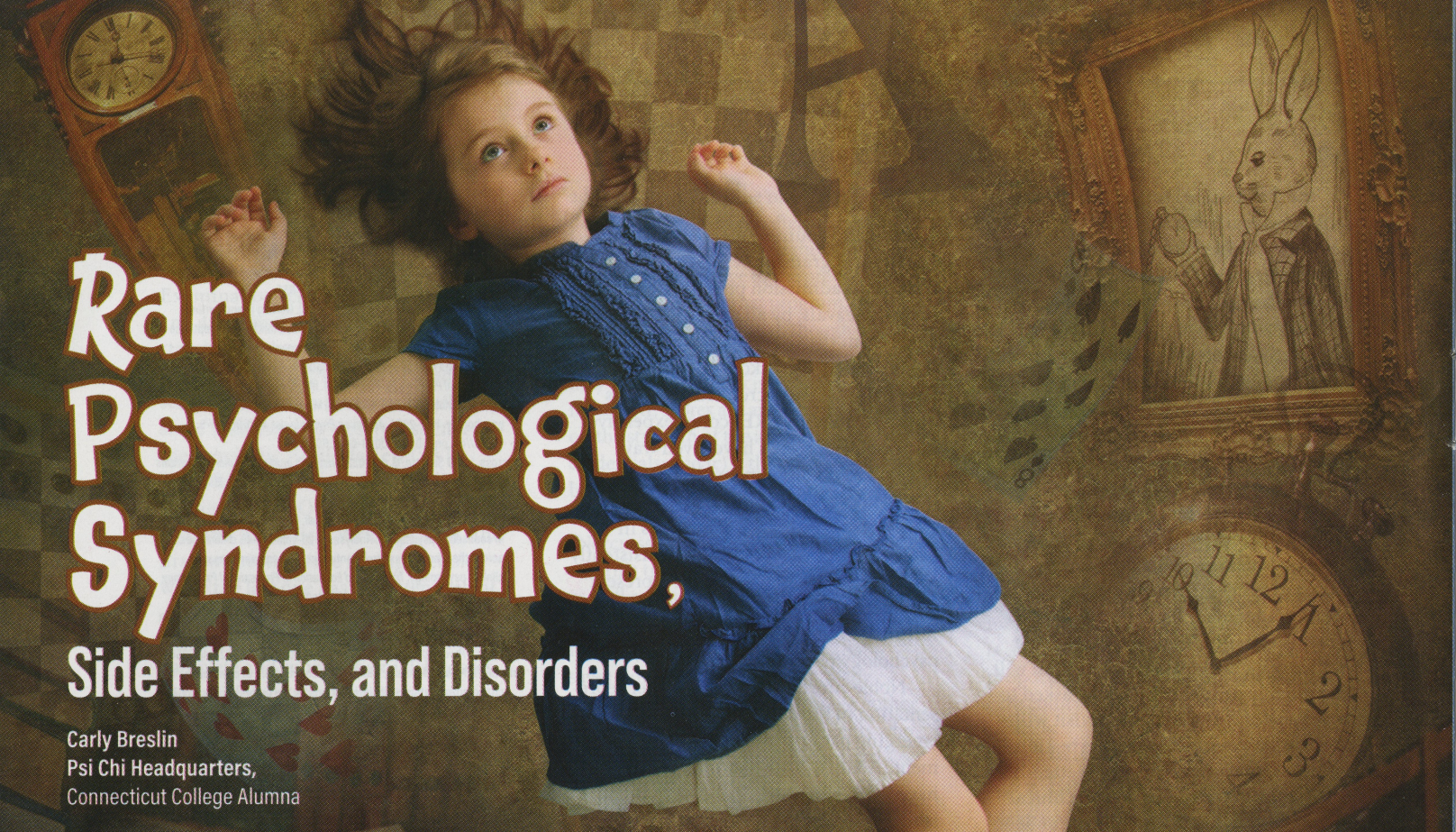
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Rare Psychological Syndromes, Side Effects, and Disorders

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Many common psychological disorders and syndromes, such as anxiety and depression, affect millions of people. But did you know that numerous others are much rarer and less understood. Sometimes, these disorders may only exist in certain cultures, or may only be seen every once in a blue moon, so to speak.¹ For this article, let's walk through a bevy of rare and fairly unknown disorders.

To put some of these conditions in context, examples throughout pop culture are included underneath some of the summaries. Keep in mind that, although we can always look for psychological themes in popular culture and media, there is not always a good representation of these themes for viewers. Warning—there will be spoilers for your favorite TV shows and movies.

I've separated the disorders below into the following categories. **Cultural** syndromes often "co-occur among individuals in specific cultural groups, communities, or contexts" (Concordia

University St. Paul, 2020). **Visual/Delusionary** diagnoses have to do with what the affected individual sees. The **Belief-Based** category refers to the affected individuals' beliefs being impacted due to the syndrome/disorder; this refers to how people think about the world, themselves, and those around them. **Urge-Based** disorders/syndromes refer to the affected individuals' uncontrollable urges. The **Bodily/Sensory** categorization includes syndromes/disorders affecting the senses and the perception of one's surroundings. Although similar to the Visual/Delusionary category, the Bodily/Sensory category does not impact one's beliefs, but instead has to do mainly with bodily function and sensation. The **Emotional** category includes mood-related disorders/syndromes that do not fit in the other categories.

Finally, it's best to keep in mind the difference between a syndrome, a disease, and a disorder. A syndrome includes symptoms that distinguish a disease, which has a distinct cause and symptoms that make up a specific process occurring in the body. Similar to the definitions of a syndrome and a disease, a disorder is a disturbance of the body's normal function (Nasrallah, 2009). Many of these conditions are not listed in the latest issue

of the DSM or of the ICD due to their rare nature. Such rarity in cases means they are less likely to be studied and thus classified.

Cultural

Khyâl Cap is a cultural phenomenon found in Cambodian and Cambodian American individuals, stemming from the Cambodian word "khyâl," which translates to wind in English, that "rises in the body with blood" (Colman, 2015; Sahlin, 2018). Similar to panic attacks, Khyâl Cap includes symptoms of "dizziness, palpitations, shortness of breath, and cold extremities, along with symptoms of anxiety and autonomic arousal, such as tinnitus and neck soreness" (Concordia University St. Paul, 2020). According to Hinton et al., this is often seen in Cambodian refugees who are also diagnosed with PTSD (2010). Although these attacks often have no trigger or warning, they are often triggered by "crowded spaces or some other stressful situation" (Sahlin, 2018). Because these attacks often involve "a great fear that death might occur from bodily dysfunction," this syndrome is also believed to be associated with psychosis (Concordia University St. Paul, 2020).

¹You'll see a play on words here when you read about Clinical Lycanthropy, a very rare condition be discussed below.

Koro Disorder is a severe fear that one's genitals will shrink and be sucked up into the body, which people afflicted with this disorder believe can result in their deaths. It is most commonly an ailment of Southeast Asian and Chinese men, but has also been found in Africa, the United States of America, and Europe in both men and women (Ntouros et al., 2010; Times of India, 2016). Those suffering from Koro tend to measure their genitals often in order to be sure they are not shrinking. Professionals often treat this disorder with behavioral therapy and antidepressants (Wong, 2021).

Kufungisisa, often seen in the Shona people of Zimbabwe, is conceptually known as "thinking too much" or "brain fog" (Concordia University St. Paul, 2020; Sahlin, 2018). Thought to cause physical and psychological pain, this disorder is often related to anxiety, panic, irritability, and depression (Sahlin, 2018). According to Patel et al. (1995), Kufungisisa refers to nonpsychotic mental, physical, and spiritual distress in an afflicted individual.

Maladi Moun is a disorder found in Haiti and Haitian communities, of a similar concept as "the evil eye," which is based on the belief that "feeling envy and malice toward another can cause harm in the form of depression, academic or social failure, psychosis, or an inability to perform daily life activities" (Sahlin, 2018).

Nervios affects individuals of Latinx (Latin American) descent in the face of upsetting events, causing physical and psychological issues, such as issues with sleep, digestion, muscle pain, and emotionality. **Ataque de Nervios** is a more extreme form of Nervios which instead can include emotional issues, such as anxiety, grief, suicidality, dissociative experiences, or physical issues including "fainting or seizure-like spasms" (Sahlin, 2018). **Ataque de Nervios** involves feeling out of control, including uncontrollable crying, screaming, and shouting. It should be noted that this condition results from a repeated buildup of emotional triggers and psychological suffering (DSM Library & Psychiatry Online, 2013).

Taijin Kyofusho is a sort of social anxiety usually found in Japanese communities. It is defined as "an intense

fear that one's body parts or functions displease, embarrass or are offensive to others" (Essau et al., 2011). Affected individuals may avoid others out of fear that their body odor, eye contact, facial expressions, facial blush, or body movements may be offensive (Sahlin, 2018). Although not mentioned in the DSM-V, this syndrome is mentioned in the DSM-IV, most likely due to the summarization of cultural syndromes into three concepts of syndromes, idioms, and explanations or perceived causes (American Psychiatric Association, 2013, p.14).

Visual/Delusionary-Based

Alice in Wonderland Syndrome aka Todd Syndrome creates a perceptual distortion in the mind of those affected, which can affect the perception of one's body image, of time, or of how one perceives the space around them. To put this in perspective, consider the tale of *Alice in Wonderland*, which shows Alice growing and shrinking, while walking through a land of strange shapes, colors, sizes, and people. Symptoms of this syndrome can include "hallucinations, sensory distortion, and an altered sense of velocity... These symptoms can trigger panic and fear responses [and] is often associated with frequent migraines, brain tumors, or drug use and can affect children between the ages of five and 10" (Concordia University St. Paul, 2020). It should be noted that this syndrome is not found in the DSM or the ICD.

Pop Culture Example:

Alice in Wonderland Syndrome is said to be highlighted in the movie *Wonderland Syndrome* (2018), showing a girl who develops Alice in Wonderland Syndrome as a side effect when she contracts pneumonia, while already struggling with epilepsy and bipolar disorder.

Charles Bonnet Syndrome includes "temporary visual hallucinations... related to pathological vision loss [and is] more common in individuals with macular degeneration, glaucoma, and diabetic retinopathy." Luckily, the syndrome clears up on its own in about 12–18 months. A common occurrence of this syndrome is something referred to as **Lilliputian Hallucinations**. Named for

the people in *Gulliver's Travels*, these hallucinations depict "people, animals, and objects of greatly reduced size" (PsychDB, 2021). Charles Bonnet Syndrome can be found in the ICD-11, also known as the International Classification of Diseases.

Pop Culture Examples:

Charles Bonnet Syndrome is thought to be the basis for Walter's hallucinations in *The Secret Life of Walter Mitty* (2013). Another example is seen in the short film, *Charlie Boy* (2016), which shows an older woman suffering from this condition.

Lilliputian Hallucinations, as mentioned in the article, derive their name from the Lilliputian people in *Gulliver's Travels*, which was a book later made into a movie in 1939 and 2010.

Cotard Delusion, also known as walking corpse syndrome is the belief that "you or your body parts are dead, dying, or don't exist." This delusion can occur during severe depression or psychosis. Symptoms of Cotard can include anxiety, hallucinations, hypochondria, guilt, and a preoccupation with hurting yourself or death (Healthline Editorial Team, 2018). **Depersonalization/Derealization Disorder** often coexists in individuals with Cotard Syndrome (Ramirez-Bermudez et al., 2010). Depersonalization/Derealization Disorder involves "a persistent or recurring feeling of being detached from one's body or mental processes, like an outside observer of one's life (depersonalization), and/or a feeling of being detached from one's surroundings (derealization)" (Spiegel, 2021). Although Cotard involves a delusional, "denial of self or one's own body... patients with depersonalization usually have preservation of judgment and reality testing," unlike in Cotard (Remirez-Bermudez et al., 2010). Cotard often occurs "more often in people who think their personal characteristics, rather than their environment, cause their behavior. People who believe that their environment causes their behavior are more likely to have a related condition called Capgras syndrome" (Healthline Editorial Team, 2018).

Pop Culture Examples:

Cotard Delusion can be seen in the *New Amsterdam* episode: "Every Last Minute." A man is brought to the hospital upon being found naked, digging in a graveyard, saying he has lost his fiancé. It turns out his fiancé is alive and well, but very worried since his going missing. When his drug screening

comes back clean, along with further discussion, it is found that he believes himself to be dead. He even goes down to the morgue and slips into one of the cadaver shelves, believing he belongs there.

Depersonalization/Derealization Disorder is said to be found in *Being John Malkovich*, although with a sort of fantastical twist of going into the mind of John Malkovich and being him. Since the movie involves outside observers entering John's mind and body and living through his life, rather than their own, one can argue that this condition is the basis for this movie. In *Black Mirror's* "Bandersnatch" episode, this condition may also be seen due to the detachment from reality the computer programmer begins to experience.

Capgras Syndrome or delusion tends to appear along with Cotard Delusions (Healthline Editorial Team, 2018). Capgras is "an irrational belief that someone they know or recognize has been replaced by an imposter" (Gotter, 2017). Capgras tends to occur in those afflicted with schizophrenia, dementia, epilepsy, or a traumatic brain injury (Concordia University St. Paul, 2020). It should be noted that Cotard is not

listed in the DSM-V, but is becoming more accepted in the scientific community.

Pop Culture Example:

Capgras Syndrome is featured in *Álfa* (2014) where a woman with this condition cannot recognize her sister or the life she is living. The show *Lore* also has an episode, "Black Stockings," in which this condition can be found. Based on a true story, the episode shows a man who believes his wife to be a changeling, a fairy that steals the identities and bodies of humans, leading him to murder her.

Reduplicative Paramnesia/ Reduplicative Amnesia is also similar to Capgras Syndrome's delusion revolving around seeing doubles, however, Reduplicative Paramnesia refers to places, rather than people. It is the "belief that a place or location has been duplicated [and] exists in two or more places simultaneously, or that it has been 'relocated' to another site" (PsychDB, 2021).

Pop Culture Example:

Reduplicative Paramnesia could be argued as the inspiration for *Vanilla Sky*, since it involves lucid dream states that duplicate places for the person in the dream to visit and live another life in.

Stendhal Syndrome, also referred to as Hyperculturemia or Florence Syndrome, results in panic, dissociation, and hallucinations in the presence of a mass quantity of art in one place or nature "that is perceived as particularly beautiful" (Concordia University St. Paul, 2020). Keep in mind also that this syndrome is not listed in the DSM at this time.

Pop Culture Example:

Stendhal Syndrome can be seen in the 1996 Italian film, *The Stendhal Syndrome*, since the main character experiences this condition while tracking a criminal to arrest him. He uses her condition to overpower and attack her, which is only the beginning of the movie. As with all movies involving mental health, be sure to take this movie with a grain of salt. Anna, the protagonist, develops more psychological issues beyond this syndrome, but not because of this syndrome. Her disassociation and subsequent violent acts come

from the trauma inflicted on her by the criminal who attacks her in the beginning of the movie, not because she has Stendhal Syndrome.

Visual Snow Syndrome involves a visual hallucination of static or snow-like dots across one's visual field. Those affected can also see hallucinogenic flashes of light, color swirls, and regular, fixed imagery. They can be prone to issues with their night vision, a sensitivity of light, migraines, tinnitus, vertigo, fatigue, tremors, anxiety, and depression. Only about 200 cases have been recorded around the world of this condition, so it is quite rare and not much else is known about it (Spelman, 2021).

Belief-Based

Aboulomania causes individuals to believe every choice they make can decide whether or not they will live or die. Those suffering from this also suffer from stress, anxiety, and depression (Times of India, 2016).

Alien Hand Syndrome is characterized by a belief that one's hand is not their own and that the hand has a life of its own; the hand can be personified as if it is its own entity. According to Concordia University St. Paul, Alien Hand Syndrome seems to be found in individuals with damage to the corpus callosum, as well as those suffering from a stroke, or damage to the parietal lobe. Someone suffering from this finds their hands acting "in opposition to one another" (2020).

Pop Culture Example:

Alien Hand Syndrome is apparently seen in *Dr. Strangelove* (1964) when Dr. Strangelove cannot stop himself from giving the Nazi salute.

Clinical Lycanthropy involves a delusion where one believes they can become an animal, similar to the myth of the werewolf. This makes sense since the etymology of the Greek word "lykanthrōpos" means werewolf, with the word "lykos" referring to wolf and the word "anthrōpos" referring to a human being (Merriam-Webster, n.d.). The delusion can refer to believing one can transform into any animal, not just wolves. Individuals with this syndrome "can act like the animal" and can be found in areas such animals may be found. According to *The Journal of Neuropsychiatry and Clinical Neurosciences*, Clinical Lycanthropy is



classified “as a type of delusional misidentification syndrome” (Concordia University St. Paul, 2020). A similar syndrome, **Boanthropy**, causes the person to believe they are a cow (Wong, 2021).

Pop Culture Example:

Clinical Lycanthropy can be observed in the movie *Wolf* (2021). The movie shows a boy, believing he is a wolf trapped in a human body, being sent to a clinic with other individuals who also believe they are animals trapped in human bodies.

Ekbom Syndrome is maybe one of the scariest syndromes on this list. Ekbom Syndrome, also called Delusional Parasitosis, is the delusion that there are bugs under one’s skin, like an infection or parasite (Schrader, 2016). This can be considered a sort of psychosis very much in need of professional help.

Pop Culture Example:

Ekbom Syndrome, or at least a variation of it, can be seen in the *Criminal Minds* episode, “The Itch,” which portrays a support group of individuals who believe they have been injected with something or that something is crawling beneath their skin.

Erotomania aka de Clerambault Syndrome is a form of psychosis, which can occur either on its own or in individuals afflicted with schizophrenia, major depressive disorder, bipolar disorder, or Alzheimer’s disorder. This psychosis-based disorder is listed as a subtype disorder in the DSM-V. It revolves around the delusion that one believes someone they have never met is in love with them. You might have heard of individuals who believe they are in love with a celebrity, someone they may never meet, but have knowledge of through social media, magazines, TV, etc. Those affected with Erotomania believe they have a connection with the person they are idolizing, which creates a disconnection with reality and between themselves and those around them. It is believed “the attachment observed in erotomania is a form of coping mechanism for managing severe stress” (Spelman, 2021).

Pop Culture Example:

Erotomania is shown in two *Criminal Minds* episodes, “Somebody’s Watching” and “Broken Mirror,” both of which involve stalkers taking drastic measures to be with the object(s) of their affection or to show their love

to the people they are obsessed with. The French movie, *He Loves Me, He Loves Me Not* (2003), also displays this condition by showing the perspective of an art student who believes the professor she is in love with will leave his wife for her, regardless of the fact that they never before met in person.

Folie a Deux is a shared delusion. If you watch *Chicago Med*, you might have seen the episode where they described this syndrome. Those suffering from this take on the symptoms of whatever psychotic disorder someone close to them may have. This can also happen in cults when the members of the cult take on and believe the delusion of their leader (Spelman, 2021).

Pop Culture Example:

Folie a Deux can be seen and explained in a *Chicago Med* episode where two women seem to share a delusion that spiraled out of control.

Fregoli Syndrome or delusion causes the affected individual to believe someone (referred to as the “persecutor”) they know is following them, and can even change how they look to blend in while pursuing the person with this syndrome. For instance, this means the affected individual, whom we will call Fregoli for this example, may believe his “persecutor” is a slight, White woman from work, but then later believe the “persecutor” has changed how they look to appear as a six-foot tall, Black man. Although these are two different people who are probably not following Fregoli, Fregoli believes they are the same person pursuing him. It can appear in individuals suffering from schizophrenia, dementia, epilepsy, or a traumatic brain injury. Although some believe Fregoli Syndrome is an offset variant of Capgras Syndrome, this is not completely true since Capgras leads to a fixation on family members being replaced with imposters, while Fregoli involves strangers masquerading as different people to follow the affected individual. According to PsychDB, “aggression can be a risk from this delusion” (2021).

Pop Culture Example:

Fregoli Syndrome can be seen in the stop-motion film, *Anomalisa* (2015), where the main character is suffering from this condition and does not recognize any of his loved ones. He even begins to see his lover as someone else whom he has never met, another characteristic of Fregoli.



Syndrome of Subjective Doubles

is similar to Capgras Syndrome. However, instead of believing someone else is a duplicate of the person they know, those with Syndrome of Subjective Doubles believe they themselves have a doppelgänger/duplicate with an entirely separate life and personality (Schrader, 2016). Just as in Capgras Syndrome, this can be extremely distressing to both the afflicted individual, and their loved ones.

Pop Culture Example:

Syndrome of Subjective Doubles could be seen in *The Sixth Day* (2000) since it involves the main character believing he has been cloned against his wishes. However, since it is a science fiction movie where cloning exists, his fears are not completely unfounded.

Urge-Based

Apotemnophilia, also known as Body Integrity Identity Disorder, causes those affected to have an urge to cut off healthy limbs, which can cause them to attempt self-amputation (Concordia University St. Paul, 2020). If a patient is believed to have this syndrome, it is best not to leave them alone with anything that may be used to aid in amputation. Afflicted individuals

seem to care more about accomplishing their goal than the pain connected to it.

Pop Culture Example:

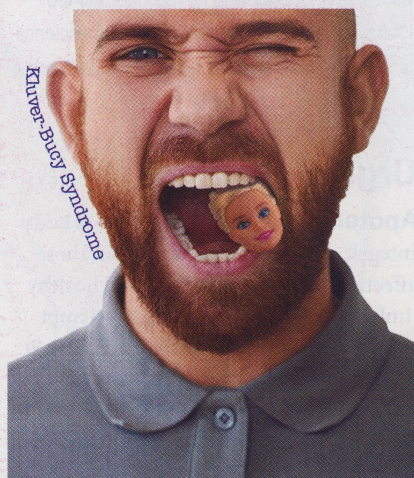
Apotemnophilia can be seen in the *Chicago Med* episode, "Us," where a man insists his arm is not his own and needs to be removed. When the doctors refuse to amputate without any medical cause, he forces their hand by using sheets in his hospital bed to block the blood flow to his arm. What you may find hard to believe, is that he is happier after the amputation is done. Please keep in mind that this is one, fictionalized account with this condition.

Diogenes Syndrome is more popularly referred to as "hoarding," the urge to collect or keep anything and everything. Mainly seen in older adults with dementia, this syndrome can also be characterized by "extreme self-neglect, apathy, social withdrawal, and a lack of shame" (Concordia University St. Paul, 2020). Although Diogenes is referred to as a syndrome in its name, it is classified as a behavioral disorder by many, but is not listed in the DSM-V. However, Hoarding Disorder is apparently classified in the DSM-V.

Pop Culture Example:

Diogenes Syndrome can be seen in the famous TLC show, *Hoarders*, where the homes of those suffering from the syndrome or related mental health issues are explored.

Klüver-Bucy Syndrome involves the overwhelming compulsion to put nonedible items in one's mouth, as well as inappropriate, hyper sexuality and attraction related to inanimate objects (Online Psychology Degree Guide, 2017). Due to damage to both



temporal lobes, one may suffer from this syndrome, along with memory loss, change in appetite, placidity, which is an extreme calm, and hyper metamorphosis, which is an extreme desire to explore. Depending on what those with this syndrome are putting into their mouths, this can be quite dangerous to their health (Wong, 2021).

Pop Culture Example:

Klüver-Bucy Syndrome is shown on an episode of *Grey's Anatomy*, "Enough is Enough," where a patient has swallowed Judy doll heads, causing a blockage in his abdomen. He refuses to tell Dr. Meredith Grey what he swallowed, saying the objects may offend her. She tells him she does not care unless they are drugs in case there is a risk the bags would pop and drugs would be released into his abdominal cavity. It is only in surgery where the truth is revealed and the patient's bowel is saved.

Disorders Related to Bodily/Sensory Function

Conversion Disorder is the sudden loss of bodily function, such as blindness or paralysis, not due to injury or illness. This condition is often due to some sort of upsetting event or psychological trigger (BrainsWay, 2021). You can find more information on this in the DSM-IV.

Pop Culture Example:

Conversion Disorder is shown in *Hollywood Ending* (2002) where Woody Allen's character becomes blind due to emotional trauma relating to this condition.

Factitious Disorder, also known as Munchausen Syndrome, is a disorder where affected individuals seek medical treatment for ailments which they do not have, by fabricating symptoms. This can apply to either physical or psychological ailments. The disorder can be broken down into two types: Self-Imposed and Imposed on Another. Self-Imposed means the individual fabricates or mimics symptoms and behaviors of an ailment in order to gain medical attention. Imposed on Another is similar, but the affected individual will fabricate the ailments for someone under their care, such as a child. If you've seen *The Act* on Hulu, Dee Dee Blanchard would be diagnosed with Imposed on Another Factitious Disorder,

based on her treatment of her child, Gypsy. Unfortunately, individuals affected by this disorder are at a higher risk to hurt themselves or those in their care in order to receive medical attention (Spelman, 2021). More information on this condition can be found in the DSM-V.

Pop Culture Example:

Factitious Disorder, also known as Munchausen Syndrome, as noted in the article, is the basis of the Hulu show, *The Act*. This show explores how Dee Dee Blanchard made her daughter, Gypsy, very sick, leading to many events that end with a murder.

Selective Mutism, similar to an extreme form of social anxiety, can be seen in young children who find they are unable to speak while at social events due to some sort of traumatic trigger (BrainsWay, 2021). This does not mean the child cannot speak at all or is refusing to speak, but that in certain situations, they are unable to. The DSM-V discusses this condition in depth for any students or practitioners interested in more information.

Pop Culture Example:

Selective Mutism is seen in *Stuck in Mute* (2015), a dramatic short where the protagonist has this disorder. Similarly, the 1997 film, *Amy*, involves a young girl who becomes only able to communicate through song, following the death of her father and the associated trauma of seeing it happen.

Synesthesia is a confusion of the senses where you may taste a candy, but also be able to somehow feel the taste or color. Some people with this condition can see different arrays of colors when they hear different kinds of music (Times of India, 2016). There are some great TikToks from people with Synesthesia describing what they sense when listening to certain music, seeing certain words, or hearing certain people speak. Because Synesthesia does not impair the lives of those who have it, it is not listed in the DSM-V.

Pop Culture Example:

Synesthesia can be shown in *Ratatouille* and in the *Criminal Minds* episode, "Magnificent Light." An animator on *Ratatouille* with synesthetic migraines incorporated inspiration from these migraines into the movie, specifically when Remy tastes food and we see a mix of colors and hear beautiful music with each taste. The



Criminal Minds episode displays an unsub with this condition who sees the words people say in different colors and fonts, leading him to believe the words in certain colors mean the person is lying or evil and must be killed. This is of course a more violent and harmful connotation of the condition than in *Ratatouille*. Remember, Hollywood is fictional and the examples are not always based in reality or good representations of real individuals with this condition.

Emotional

Paris Syndrome is an extreme disappointment upon seeing Paris. You would think this is just a personal let-down that people get past easily, but it is a real condition where those suffering from it endure hallucinations, anxiety, dizziness, sweating, and nausea. It relates to a detachment from reality where the Paris those suffering imagine it to be, is in fact not like what they perceive the reality of the city to be (Wong, 2021).

Postpartum Psychosis is a rare offset of Postpartum Depression, which is much more common. Postpartum Depression is a type of depression, which affects mothers after giving birth. In contrast, Postpartum Psychosis is an extremely rare version where mothers experience delusions, confusion, mood-related issues, and paranoia (BrainsWay, 2021). This specific offset of psychosis is in fact listed in the DSM-V if you wish to learn more about it.

Pop Culture Example:

Postpartum Psychosis is shown in the *Law and Order: Criminal Intent* episode, "Magnificat," where a mother tries to kill herself and her children because she believes it to be for all of their best interests. The 2008 movie, *Baby Blues*, also displays this condition when a mother tries to harm her children due to a psychotic episode, leading her oldest son to protect the rest of the family. Unfortunately, this condition is not shown in many happy movies or TV shows due to the fact that Hollywood pushes it to its most dangerous and extreme form. If you or someone you know is experiencing Postpartum Depression or Psychosis, help is available. There are many resources, such as Postpartum Support International, <https://www.postpartum.net/get-help/help-for-moms/>, but keep in mind that 9-1-1 should always be used first and foremost in an emergency.

Keep in mind that diagnoses are constantly changing and disorders/syndromes that may be widely acknowledged but not noted in the current version of the DSM may be included in the next version. Have you known anyone who has suffered from any of these disorders? Chances are, you probably won't meet someone who suffers from these ailments, due to their rarity, but they're definitely interesting to learn about. A key takeaway from knowing there are people living with these syndromes and disorders is to recognize that whatever psychological issues you may be dealing with, you're not alone. Whether you have a rare disorder like the ones discussed here or a more common syndrome, you are not the only person with this syndrome/disorder and support is available.

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